

UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

PORTLAND DIVISION

BARBARA PAULSON,)
)
Plaintiff,) No. 03:11-cv-00556-HU
)
vs.)
)
MICHAEL J. ASTRUE,) **FINDINGS AND RECOMMENDATION**
Commissioner of Social Security,)
)
Defendant.)

H. Peter Evans
Steven J. Munson
H. Peter Evans PC
308 SW First Avenue, Suite 200
Portland, OR 97204

Attorneys for Plaintiff

S. Amanda Marshall
United States Attorney
Adrian L. Brown
Assistant United States Attorney
1000 S.W. Third Avenue, Suite 600
Portland, OR 97204-2904

David Morado
Regional Chief Counsel, Region X, Seattle

Daphne Banay
Special Assistant United States Attorney
Office of the General Counsel
701 Fifth Avenue, Suite #2900 M/S 901
Seattle, WA 98104-7075

Keith D. Simonson
Special Assistant United States Attorney
Social Security Administration
Office of the General Counsel
1301 Young Street, Suite A702
Dallas, TX 75202

Attorneys for Defendant

1 - FINDINGS & RECOMMENDATION

HUBEL, United States Magistrate Judge:

The plaintiff Barbara Sue Paulson seeks judicial review pursuant to 42 U.S.C. § 405(g) of the Commissioner's final decision denying her application for Disability Insurance ("DI") benefits under Title II of the Social Security Act, 42 U.S.C. § 1381 *et seq.* Paulson argues the Administrative Law Judge ("ALJ") erred in finding her testimony not to be fully credible, discounting her husband's lay testimony, and improperly rejecting the opinion of her treating healthcare provider. See Dkt. # 19.

I. PROCEDURAL BACKGROUND

Paulson protectively filed her application for DI benefits on September 15, 2008, at age 47, claiming disability since May 28, 2008, due to chronic pain in her tailbone, shoulders, neck, and back. She also alleges impairments including chronic, severe constipation; degenerative disc disease of the lumbar spine; depression; migraine headaches; nicotine dependence; aortic valve regurgitation; ovarian cysts; insomnia; and problems with memory and concentration. (A.R. 18, 20, 39, 145, 165¹) Paulson's application was denied initially and on reconsideration. (A.R. 92-96, 98-101) She requested a hearing, and a hearing was held on January 15, 2010, before an ALJ. Paulson testified on her own

¹The administrative record was filed electronically using the court's CM/ECF system. Dkt. #14 and attachments. Pages of the record contain three separate page numbers: two located at the top of the page, consisting of the CM/ECF number (e.g., Dkt. #14-3, Page 19 of 82); a Page ID#; and a page number located at the lower right corner of the page, representing the numbering inserted by the Agency. Citations herein to "A.R." refer to the agency numbering in the lower right corner of each page.

1 behalf. Also testifying were Paulson's husband Charles, and a
 2 Vocational Expert ("VE"). (A.R. 33-74) On February 3, 2010, the
 3 ALJ issued his decision, denying Paulson's application for DI
 4 benefits. (A.R. 15-29) Paulson appealed the ALJ's decision, and
 5 on March 7, 2011, the Appeals Council denied her request for review
 6 (A.R. 1-4), making the ALJ's decision the final decision of the
 7 Commissioner. See 20 C.F.R. §§ 404.981, 416.1481. Paulson filed
 8 a timely Complaint in this court seeking judicial review of the
 9 Commissioner's final decision denying her application for benefits.
 10 Dkt. #2. The matter is fully briefed, and the undersigned submits
 11 the following findings and recommended disposition of the case
 12 pursuant to 28 U.S.C. § 636(b)(1)(B).

13 14 **II. FACTUAL BACKGROUND**

15 **A. Summary of the Medical Evidence**

16 On September 20, 2004, Paulson was seen by a doctor at a
 17 Kaiser Permanente clinic² for complaints of chronic coccyx and
 18 sacroiliac pain. She was referred to a rehabilitation specialist.
 19 (A.R. 289)

20 On October 16, 2004, Paulson was seen in the emergency room
 21 for complaints of acute pain in her lower back, and an acute lumbar
 22 strain. She received a prescription for Percocet, and was directed
 23 to follow up with her regular doctor. (A.R. 290) On October 21,
 24 2004, Paulson was referred for physical therapy in connection with
 25 a diagnosis of sacral/coccyx pain. (A.R. 298-99)

26
 27
 28 ²Unless otherwise identified, all of Paulson's treating
 sources have been associated with Kaiser clinics and hospitals.

1 The next evidence of medical treatment for Paulson is nineteen
2 months later, when she saw family practitioner Susan Blake, M.D.,
3 on May 2, 2006, with a complaint of "worsening coccygeal/pelvic
4 pain." (A.R. 227) Notes indicate ovarian cysts had been seen on
5 an MRI, and she was scheduled for an ultrasound. She was taking
6 extended-release morphine, which she stated made her "'fuzzy' and
7 unable to focus," and she stated she did better on oxycodone.
8 (A.R. 227) Cyclobenzaprine was added to her medication regimen.
9 (*Id.*) Paulson was noted to be 5'5" tall, and at the time of this
10 visit, she weighed 163 pounds. (A.R. 229)

11 The ultrasound of Paulson's pelvis was performed on May 4,
12 2006, and showed "[p]robable small debris-containing or hemorrhagic
13 cysts or follicles within the ovaries." (A.R. 235) On May 12,
14 2006, Paulson saw gynecologist Lydia Helen Collins, M.D. for
15 followup regarding the ovarian cysts. The doctor indicated it was
16 unlikely that Paulson's chronic coccyx-area pain was caused by the
17 cysts, and she directed Paulson to have the cysts rechecked in six
18 months to a year. (A.R. 226-27)

19 On June 1, 2006, Paulson saw Physical Medicine and Rehabilita-
20 tion Specialist Jean M. Wyles, M.D. Dr. Wyles administered a local
21 corticosteroid injection in the area of Paulson's coccyx. (A.R.
22 226) The injection only provided about one day of relief, and
23 Dr. Wyles administered a second injection on June 22, 2006.
24 (A.R. 225-26) The doctor noted that if this injection was not
25 helpful, she would consider prescribing a course of oral steroids,
26 which Paulson indicated had been helpful in the past. (A.R. 226)

27 On June 27, 2006, Paulson saw gynecologist Wendy J. Smith,
28 M.D. for a second opinion "regarding ovarian cysts and severe low

1 back pain/coccydynia." (A.R. 224) Paulson's weight had increased
2 to 170 pounds. (A.R. 229) Paulson described a three-year history
3 "of daily severe and worsening 'tailbone' pain," worse when she was
4 sitting and getting up. (A.R. 224) She had received some
5 injections, but the pain had gotten worse, and now was "constant."
6 (*Id.*) When she had an MRI to evaluate this pain, an ovarian cyst
7 was identified, and the physiatrist questioned whether the cyst
8 could be the source of Paulson's pain. In addition, Paulson
9 reported being extremely constipated, with a bowel movement only
10 about once every two weeks. She was taking oxycodone regularly for
11 her pain. Dr. Smith did not believe the cysts needed any further
12 evaluation. She also did not believe the cysts were the source of
13 Paulson's tailbone pain, noting it would be "unusual for coccydynia
14 to be so limiting." (A.R. 224) However, she noted it was possible
15 that scarring from Paulson's prior surgeries (including a hysterec-
16 tomy) might be an issue. (A.R. 225)

17 On Saturday, July 8, 2006, Paulson was seen at an urgent care
18 clinic for a complaint of low back pain. (The progress note does
19 not indicate who saw Paulson on this occasion. See A.R. 223.)
20 Paulson was "on chronic narcotic therapy," taking four 5 mg
21 oxycodone pills every three hours for pain. She had received 160
22 pills at the end of June, and stated she had run out the previous
23 Wednesday. She had been told to see her primary care provider,
24 Susan Blake, M.D., that Wednesday, which she "forgot" to do, and
25 she was "[r]equesting a narcotic injection," which was denied.
26 (A.R. 224) She was given 30 oxycodone pills, "and told she

1 absolutely must follow up with [Dr. Blake] on Monday." (*Id.*)
2 There is no indication in the Record that she complied with this
3 direction.

4 On February 15, 2007, Paulson talked with Dr. Blake by phone
5 regarding complaints of fatigue. Paulson stated, "I'm all of a
6 sudden having a hard time functioning." (A.R. 337) She was
7 sleeping for two or three days at a time, but then at other times
8 she was unable to sleep. Paulson stated this cycle had been
9 ongoing for several months, she was missing work, and her family
10 members were becoming concerned. The doctor ordered lab tests to
11 rule out any metabolic explanation for Paulson's symptoms. If labs
12 were normal, then she opined Paulson's depression might not be
13 treated adequately, noting her narcotic pain medications could make
14 her depression worse. (*Id.*)

15 On February 28, 2007, Paulson talked with Dr. Blake by phone
16 to discuss symptoms of weakness, fatigue, and sleeping constantly.
17 She also requested a note for work. The doctor noted Paulson's
18 antidepressant medication had been changed to Celexa on
19 February 15, 2007. Paulson's lab results were normal, and the
20 doctor referred Paulson to a neurologist "to check for causes of
21 hypersomnia." (A.R. 336) She also switched Paulson from Celexa to
22 Prozac (fluoxetine). (*Id.*)

23 On May 25, 2007, Paulson saw Physical Medicine and Rehabili-
24 tation specialist James Y. Kim, M.D. for consultation regarding her
25 ongoing tailbone pain. Paulson's weight had increased to 176
26 pounds. (A.R. 228) Paulson gave the following history of her
27 tailbone pain:
28

1 The patient states that about 4 years ago she
2 went on a salmon fishing trip. She was
3 sitting on a hard surface as they were going
4 out on the boat. The boat was on some choppy
5 waters, going at high speeds, and she remem-
6 bers repeatedly bouncing up and down on a hard
7 surface right on her tailbone. Then she spent
8 several hours just sitting on that same spot,
9 and ever since then she has had pain in her
10 low back. At first the pain was only present
11 when sitting on a hard surface. Over the
12 years it has gradually worsened, and now her
13 pain is constant. It involves an area which
14 seems to correspond to her entire sacrum. It
15 will hurt whether she is sitting or standing.
16 She describes the pain as like a severe ache.
17 She rates it 8 over 10. She denies any pares-
18 thesias in her lower extremities or saddle
19 anesthesia, denies any weakness in her lower
extremities, denies any bowel or bladder
incontinence. It seems to decrease when she
is able to apply heat. She is also taking
oxycodone to relieve her symptoms. It does
not seem to change with bending, lifting,
twisting, coughing, or sneezing. She is
currently using up to 784 tablets of oxycodone
a month [i.e., 26 pills per day]. These are 5
mg tablets. She has never been to see a
chiropractor or physical therapist. She did
come to see one of our colleagues who tried
triple injections near the tailbone, and this
did give her some relief for perhaps a few
days at most; however, it was not much more
than that. She states she has had oral
prednisone and this actually gave her more
relief than anything else.

20 (A.R. 221) Notes also indicate Paulson's past medical history was
21 "[s]ignificant for aortic insufficiency, migraine headaches,
22 depression, [and] coccydynia [i.e., tailbone pain]." (*Id.*)

23 Paulson's current medications at the time of this visit
24 included, *inter alia*, oxycodone (a narcotic pain medication),
25 fluoxetine (an antidepressant), cyclobenzaprine (a muscle relax-
26 ant), lorazepam (an anti-anxiety medication), Topamax (a medication
27 used to treat migraines, among other things), citalopram (another
28 antidepressant), and nifedipine (a calcium channel blocker, used to

1 treat angina).³ (*Id.*) Paulson reported smoking half a pack of
2 cigarettes a day. She was unemployed, stating she "spen[t] her
3 time taking care of her grandson." (A.R. 222)

4 On examination of Paulson's back, the doctor noted no redness
5 or swelling. Paulson exhibited "tenderness to palpation over the
6 SI joints and over the buttocks bilaterally[,]" but pressure over
7 her coccyx area did not elicit tenderness. (*Id.*) Her ranges of
8 motion were flexion 89 degrees, extension about 20 degrees, and
9 lateral flexion 20 degrees bilaterally.⁴ She exhibited no
10 tenderness with movement of her hips, and all ranges of motion for
11 her hips were within normal limits. The doctor noted an MRI of
12 Paulson's sacrum and coccyx "showed some areas of fatty marrow but
13 otherwise was read as normal." (*Id.*)

14 Dr. Kim noted the following assessment from his examination of
15 Paulson and review of her MRI results: "Low back pain possibly
16 secondary to coccydynia, SI (sacroiliac) joint pain, piriformis
17 syndrome, or a combination of any of these. I also cannot
18 completely rule out discogenic pathology although this seems very
19 unlikely." (*Id.*) He recommended a caudal epidural steroid injec-
20 tion; directed Paulson to use a lumbar support when sitting, and
21
22

23 ³Information on all of these medications was obtained from
24 www.rxlist.com.

25 ⁴The Oregon Department of Consumer and Business Services,
26 Workers' Compensation Division, has adopted norms established by
27 the AMA Guides for spinal ranges of motion. The norms for lumbar
28 ranges of motion are flexion 60 degrees, extension 25 degrees, and
lateral flexion 25 degrees bilaterally. See [www.cbs.state.or.us/
external/wcd/rdrs/mru/forms.html](http://www.cbs.state.or.us/external/wcd/rdrs/mru/forms.html) (visited Sept. 24, 2012) (forms
2278C, 2278L, and 2278C).

1 try to stay off her coccyx as much as possible; and directed her to
2 perform stretching exercises for several weeks. (*Id.*)

3 Dr. Kim administered an epidural steroid injection on June 29,
4 2007, with "no immediate complications." (A.R. 220) Paulson saw
5 Dr. Kim on August 31, 2007, reporting that "the last injection did
6 not help very much." (A.R. 218) Dr. Kim administered another
7 epidural injection. (A.R. 218-19)

8 On September 18, 2007, Paulson talked with Dr. Blake by phone
9 regarding her ongoing coccyx pain. Paulson stated the steroid
10 injections had not helped. She asked for a prescription for Valium
11 to use as needed to help her sleep. (A.R. 331)

12 On October 15, 2007, Paulson began tapering off oxycodone and
13 started taking methadone. Dr. Blake followed up with Paulson by
14 phone on October 24, 2007. The doctor opined Paulson "might
15 benefit from Pain Clinic pain classes." (A.R. 329) On Novem-
16 ber 20, 2007, Paulson called Dr. Blake, and reported her coccyx
17 pain was returning since she had stopped the oxycodone. (A.R. 328)

18 On December 15, 2007, Paulson saw Physician's Assistant
19 Christine F. Legler to have a painful, infected boil drained.
20 Paulson's weight had increased to 185 pounds. (A.R. 228)
21 Paulson's prescription for oxycodone was refilled, and she also
22 received a prescription for an antibacterial medication. (A.R.
23 217-18)

24 On March 12, 2008, Paulson saw family practitioner Xianghong
25 Zhu, M.D. with complaints of neck pain and stiffness, associated
26 with right shoulder and arm pain for three weeks. Paulson stated
27 it was painful to use her arm, and the pain was affecting her
28 sleep. She also had some mild numbness in her right index finger.

1 She was taking Ibuprofen and Flexeril, without any significant
2 relief. (A.R. 215-16) Paulson's weight had increased to 189
3 pounds. (A.R. 228) On examination, the doctor noted moderate
4 muscle spasms and tenderness to palpation along Paulson's shoulder
5 and upper back muscles, as well as significant tenderness along the
6 lateral aspect of Paulson's right upper arm, where "palpation put
7 her into tears for which she apologized profusely." (A.R. 216)
8 Her upper extremity strength was within normal limits, although she
9 complained of moderate pain with motion. Dr. Zhu ordered tests and
10 x-rays, and prescribed pain medications and physical therapy.
11 (*Id.*)

12 On March 28, 2008, Paulson talked with Dr. Blake to request a
13 change in her medications. She stated the long-acting pain
14 medications were not working well, and she wanted to try taking
15 Vicodin for "half of her pain meds." (A.R. 25) The doctor wrote
16 new prescriptions for Paulson's medications. (*Id.*)

17 Paulson was seen in the ER on May 5, 2008, with complaints of
18 an exacerbation of her low back pain in the right side, radiating
19 down the back of her thigh but not below her knee. (A.R. 354-55)
20 An x-ray examination was normal for her age, showing "[n]o
21 significant subluxation and no remarkable focal osseous abnormali-
22 ties." (A.R. 234) Paulson was treated with 2 mg of IM Dilaudid,
23 1 mg of IM Ativan, and then another 2 mg of IM Dilaudid. She had
24 "good improvement in her discomfort," and was discharged with a
25 prescription for Dilaudid 2mg to 4 mg every six hours as needed for
26 breakthrough pain. (A.R. 355-56)

27 On May 6, 2008, Paulson saw Internal Medicine specialist
28 Michele D. McCallum, M.D. for followup. Paulson's weight was down

1 slightly, to 186 pounds. (A.R. 228) Paulson stated her tailbone
2 pain was "excruciating," and so severe that she could not live with
3 it any longer. (A.R. 215) She stated it was "worsening her
4 depression." (*Id.*) Steroid injections had not been helpful, and
5 she was frustrated at having to take high doses of pain
6 medications. The doctor referred Paulson to a physiatrist, and
7 recommended trials of a TENS unit and acupuncture. She noted
8 Paulson was not a candidate for chiropractic treatment at that time
9 due to secondary radicular symptoms, but Paulson noted this was the
10 first time she had experienced those symptoms, so the doctor opined
11 chiropractic treatment might be an option in the future. (*Id.*)
12 Paulson's medication records indicate she was still taking narcotic
13 pain medications at this time (A.R. 213), and she had signed a pain
14 contract (A.R. 215).

15 On June 12, 2008, Paulson saw Dr. Kim for followup of her
16 ongoing tailbone pain. Paulson stated she had been seen in the ER
17 for an exacerbation of her pain, with radiation into the right
18 femoral area and the anterior thigh. She stated it took two
19 injections before the pain improved. She vomited "several times"
20 the next day, and then felt better. She was obtaining limited
21 relief from acupuncture, but two to three days after a treatment,
22 her pain would return. She stated the pain was present throughout
23 her lower lumbar spine, usually without radiation, although she
24 sometimes felt weakness in her legs. The doctor ordered a bone
25 scan. He noted that if the scan was "not helpful," then he would
26 "consider SI joint injection and possibly further imaging of the
27 actual lumbar spine itself." (A.R. 214)

28 / / /

11 - FINDINGS & RECOMMENDATION

1 On July 8, 2008, Paulson had a bone scan to evaluate her six-
2 year history of coccygeal pain, and low back pain. The study
3 showed "[n]o vertebral, sacral, or coccygeal osteoblastic
4 abnormality . . . and no lumbosacral abnormality. . . ." (A.R. 233)

5 On August 4, 2008, Paulson talked with Susan Blake, M.D. by
6 phone regarding Paulson's back pain and depression. Paulson had
7 "sent another long, desperate-sounding . . . message, relating
8 worsening of her back pain and fatigue, inability to get out of bed
9 and function." (A.R. 323) Paulson stated she was okay while lying
10 down with a heating pad, but as soon as she stood up for any length
11 of time, her low back pain worsened, and her legs felt weak. The
12 doctor indicated an MRI of her lumbar spine would help determine
13 whether there was some spinal stenosis causing Paulson's symptoms.
14 Paulson had been quite depressed, which the doctor did not find
15 surprising, noting Paulson previously had been "a very active
16 woman, and now can do hardly anything without pain." (*Id.*) The
17 doctor ordered a trial of Effexor, and discontinued the Prozac
18 (fluoxetine). (*Id.*)

19 Paulson had an MRI of her lumbosacral spine on August 18,
20 2008. The study showed "mild multilevel degenerative changes
21 within the lumbar spine," but "[n]o advanced stenoses or definite
22 neural impingement." (A.R. 232)

23 On November 20, 2008, clinical psychologist Dorothy Jean
24 Anderson, Ph.D. reviewed the record and completed a Psychiatric
25 Review Technique form. (A.R. 249-62) Dr. Anderson indicated
26 Paulson's "medical records suggest her depression stems primarily
27 from her chronic coccyx pain, which has been present since
28 [approximately] 2003. . . . Neither pain nor depression prevented

1 her from continuing gainful employment up to 5/28/08." (A.R. 261)
2 She noted Paulson had not evidenced any "problems with concen-
3 tration, comprehension, or formulating answers to questions" during
4 her telephone claim interview by a Social Security representative,
5 and progress notes did not show any "significant impairment of
6 cognitive function." (*Id.*) Dr. Anderson indicated medical records
7 substantiated Paulson's "complaints of being unable to focus when
8 using extended-release morphine, but [she] does better on oxycodone
9 (the medication she's currently maintained on)." (*Id.*) She noted
10 Paul's husband claims Paulson has memory problems, and concen-
11 trating "hurts" her, but she found no substantiation in the Record
12 for his claims. Dr. Anderson opined Paulson has a medically-
13 determinable impairment of recurrent major depression (see *id.*;
14 A.R. 252), but the impairment "does not pose any severe limitation
15 of work-related mental functioning." (*Id.*) She further opined
16 Paulson has mild restriction of her activities of daily living, and
17 mild difficulties in maintaining concentration, persistence, or
18 pace, but no difficulties in maintaining social functioning, and no
19 episodes of decompensation. (A.R. 259)

20 The same day, November 20, 2008, Physical Medicine and
21 Rehabilitation specialist Mary Ann Westfall, M.D. reviewed the
22 record, and completed a Physical Residual Functional Capacity
23 Assessment form. (A.R. 263-70) She found Paulson would be able to
24 lift/carry up to twenty pounds occasionally and ten pounds
25 frequently; stand and/or walk, and sit, for about six hours each in
26 an eight-hour workday; and push/pull without limitation. In
27 reaching her opinion, Dr. Westfall noted Paulson "complained of
28 coccygeal pain for several years before she actually stopped

1 working (5/28/08), as shown in her medical records. She alleges
2 she sustained coccyx injury back in 2003 (according to her claim @
3 5/25/07 exam)." (A.R. 264) She noted Paulson's chronic constipa-
4 tion could be caused by her regular use of oxycodone, and the
5 "constipation could account for some of [Paulson's] low back
6 complaints." (*Id.*)

7 Dr. Westfall indicated her residual functional capacity
8 findings took into consideration Paulson's complaints of pain, and
9 her mild lumbar degenerative disc disease findings. (A.R. 265)
10 She also took into account the claims of Paulson's husband that
11 Paulson "spends the entire day in bed w/heating pad, secondary to
12 the severity of her pain, [and] no longer does any of the household
13 cleaning/cooking. [Mr. Paulson] estimates [his wife] can only lift
14 about 5#, stand 5 minutes, [and] has pain with reaching, walking,
15 sitting, kneeling, or climbing stairs." (A.R. 268)

16 Dr. Westfall acknowledged that Paulson's doctors' ongoing
17 prescriptions for narcotic pain medications "lend[] some credence
18 to her complaints, but the general lack of significant findings on
19 objective exam (such as claim of [lower extremity] weakness not
20 supported on 6/08 exam) counteracts this." (*Id.*) As explanation
21 for Paulson's ongoing coccyx pain despite a lack of objective
22 findings, Dr. Westfall opined Paulson "may simply have a lower pain
23 threshold than objective findings alone would support." (*Id.*)

24 Paulson talked with P.A. Dori Macdonald ("PA Macdonald") on
25 December 15, 2008, regarding a complaint of insomnia. She noted
26 her husband snored loudly. PA Macdonald prescribed a trial of
27 Ambien. Regarding her coccyx pain, Paulson stated her pain was
28 10/10 without medication, but on the oxycodone, it was usually a

1 6/10. She was encouraged to exercise and stretch, which she was
2 not doing. She was taking Effexor 50 mg twice daily for
3 depression. Notes indicate she was "[l]aid off last May 2008," and
4 had been unable to return to work due to her medications and her
5 pain threshold. (A.R. 275-76)

6 On January 8, 2009, psychologist Megan D. Nicoloff, Psy.D.
7 reviewed the record in connection with Paulson's request for
8 reconsideration, for purposes of preparing a "Mental Summary."
9 (A.R. 278) Dr. Nicoloff affirmed the prior assessment that Paulson
10 has no severe mental problems. She noted Paulson has not alleged
11 a psychological impairment, and the medical evidence suggests her
12 depression "is primarily related to her chronic pain which she has
13 been dealing with for several years." (*Id.*) Although Kaiser
14 records show a diagnosis of major depression since 2005, the
15 records contained "limited reference to any psych complaints and
16 this has been treated only by [medication;] no counseling or
17 therapy has been requested." (*Id.*)

18 Also on January 8, 2009, Martin Kehrli, M.D., a Hospice Care
19 and Palliative Medicine specialist, reviewed the record in connec-
20 tion with Paulson's request for reconsideration, for purposes of
21 preparing a "Physical Summary." (A.R. 279) He affirmed the prior
22 finding that Paulson would be capable of doing light work. He
23 found Paulson's statements about her functional abilities not to be
24 fully credible, noting Paulson claims she "is in bed 24/7," yet her
25 doctor's notes "reflect [Paulson] spends time caring for a
26 grandson." (*Id.*) Paulson claims she can only lift five pounds and
27 only walk a few feet, "yet objective findings show she has normal
28 strength and sensation and no significant stenosis on imaging."

1 (*Id.*) In addition, he noted Paulson continued to work for several
2 years in spite of her pain, until May 2008. He indicated Paulson's
3 degenerative disc disease in her lumbar spine could limit her
4 ability to lift heavy weights. (*Id.*)

5 On March 2, 2009, PA Macdonald ordered lab tests and a routine
6 mammogram for Paulson. Notes indicate Paulson was taking a
7 medication for constipation; morphine 15 mg/ml injectable up to
8 once a week as needed for pain; morphine 15 mg tablets, one every
9 six hours for pain; and Meloxicam, a nonsteroidal antiinflammatory
10 medication, "for arthritis." (A.R. 302-03)

11 On March 24, 2009, PA Macdonald prescribed a TENS unit for
12 Paulson. (A.R. 307)

13 On August 4, 2009, PA Macdonald changed Paulson's medication
14 regimen, directing her to try taking one morphine tablet every
15 eight hours for two days; then increase to 30 mg in the morning, 15
16 mg at midday, and 30 mg at night. She also referred Paulson to a
17 pain management specialist. Records indicate Paulson's weight at
18 this time was 194 pounds. (A.R. 311) In addition, Paulson signed
19 an updated opiate therapy plan. (A.R. 315-18)

20 In August 2009, Paulson completed an intake form at a pain
21 management clinic. On the form, she indicated she experiences
22 constant pain that is burning and sharp in character. She has
23 muscle weakness in her back, and does not exercise. (A.R. 281)
24 She rated her pain at 8/10 to 9/10, indicating pain interferes with
25 her mood, activities, sleep, relationships, and general enjoyment
26 of life. She indicated she obtains some relief from heat,
27 medications, and a TENS unit, as well as lying down with no
28 pressure on her back. (A.R. 282) Getting up and being active

1 makes her pain worse. She indicated she wanted to "get medications
2 that will help [her] pain and any exercises that [may] help [her]
3 as well." (*Id.*) Paulson further indicated she was unable to work
4 due to pain, last working on May 27, 2008. She drank four cans of
5 soda and smoked half a pack of cigarettes per day. She listed her
6 current weight as 190 pounds. She indicated she is depressed, has
7 trouble concentrating, and has trouble sleeping nearly every day,
8 and she sometimes had suicidal or self-harm thoughts. (A.R. 283)
9 She listed her current medications as Trazodone and Fluoxetine for
10 depression, Topiramate for migraines, short-acting morphine and
11 oxycodone for pain, and diazepam for anxiety. She indicated she
12 also sometimes takes over-the-counter sleep medications because her
13 pain is worse at night. (A.R. 284)

14 On January 11, 2010, PA Macdonald completed a Physical
15 Capacities Evaluation form.⁵ She opined Paulson could sit, stand,
16 and walk, each, for about half an hour at a time; sit for no more
17 than one hour, and stand and walk for no more than two hours,
18 total, during a normal workday; lift up to ten pounds occasionally,
19 carry up to five pounds occasionally, and never lift or carry any
20 greater amounts; use her hands for simple grasping, pushing and
21 pulling, and fine manipulation, without limitation; use her feet to
22 operate foot controls "for [a] limited time"; bend occasionally;
23 reach above shoulder level occasionally; and never squat, crawl, or
24 climb. (A.R. 371) She opined Paulson would have no restriction of
25

26
27 ⁵At the ALJ hearing, Paulson testified this form was not
28 completed just by reference to her medical records. She stated
PA Macdonald checked her strength by having Paulson push against
PA Macdonald's hands with her legs and arms. (See A.R. 37-38)

1 activities involving work at unprotected heights, and exposure to
2 dust, fumes, and gases; and Paulson would have mild restriction of
3 activities involving being around moving machinery, driving
4 automotive equipment, and being exposed to marked changes in
5 temperature and humidity. (A.R. 372) PA Macdonald stated Paulson
6 "is functionally incapacitated due to her chronic long term pain
7 and now weakness in her extremities that disallows repetitive work.
8 I do not believe she is able to sustain employment." (*Id.*) She
9 further opined Paulson would miss more than four days of work per
10 month due to her inability to sustain activities for a full
11 workday. (*Id.*) In a letter dated January 13, 2010, PA Macdonald
12 further indicated Paulson "is limited in her ability for normal
13 capacity for work due to inability to sustain either standing or
14 sitting for a length of time. She is limited to working with
15 machinery due to the daily narcotic medications she uses to control
16 her pain. Subsequent to the restriction of her activity and
17 chronic pain for the last 8 years, I believe that she is unable to
18 be employed." (A.R. 374)

19 On February 16, 2010, Paulson called to request a refill of
20 her morphine, stating she had been out of the medication for two
21 weeks "due to Husband's decrease in pay (had to wait until this pay
22 day to request refill)." (A.R. 423) She was scheduled for a
23 telephone appointment with James Mark Bertola, M.D., an
24 anesthesiologist and pain management specialist. The doctor wanted
25 Paulson to get a new urine drug screen prior to authorizing any
26 refill of the morphine, and he wanted her to discontinue use of the
27 oxycodone. Paulson "became very upset and confrontational as
28 [they] talked about the reasons behind" the doctor's recommenda-

1 tions. (A.R. 422) The doctor offered to refer her to a colleague
2 for a second opinion. He transferred Paulson to the scheduler, but
3 Paulson declined an appointment, noting she was working with
4 PA Macdonald, and was starting physical therapy. (A.R. 422)

5 Later the same day (February 16, 2010), Paulson attempted to
6 reach PA Macdonald by phone. Paulson was crying and said she was
7 feeling suicidal. The emergency service was able to reach
8 PA Macdonald, who attempted to call Paulson, but a "crying young
9 girl answered the phone - stated that [Paulson] had taken a lot of
10 her pills and was being taken to [the hospital] by ambulance."

11 (A.R. 419, 420) Paulson was seen in the ER "for evaluation of
12 depression and overdose." (A.R. 433) Notes indicate she had been
13 on a combination of oxycodone and oral morphine for quite some
14 time, and had run out of her morphine two weeks earlier. When she
15 called the pain clinic for a refill, she was unable to reach her
16 primary care doctor, and Paulson stated the doctor she spoke with
17 "was very rude and refused [to] refill her pain medicine." (*Id.*)
18 Paulson called "911" and asked them to talk with her doctor. When
19 she was told they could not do this, she took "a handful of
20 oxycodone." (*Id.*) She was brought in by police, and was on a
21 police hold. On arrival at the ER, Paulson was "upset, crying,
22 tearful, saying that she is very depressed and wants to die and
23 relates it entirely to this interaction today with this other
24 physician." (*Id.*) Notes indicate Paulson was "[n]ot a smoker."
25 (*Id.*) Doctors believed Paulson's ongoing risk for self-harm was
26 "quite high, based on her statements and her actions." (A.R. 434)
27 Paulson continued to state she wanted to die, and wanted to return
28

1 home and finish the job. She agreed to be admitted to the
2 psychiatric unit for evaluation. (A.R. 434-35)

3 The next day, Paulson tried to reach PA Macdonald from the
4 hospital, again requesting a refill of her morphine and a
5 prescription for Valium. Paulson stated she had not slept in two
6 days, and she needed her medication and wanted to go home. Paulson
7 talked with a nurse at PA Macdonald's office, who advised her to
8 work with the hospital staff "to help her stay safe," and Paulson
9 agreed to do so. (A.R. 416) Paulson was evaluated by a psychia-
10 trist, who determined she was no longer at risk of harming herself,
11 and she was "discharged to the care of her family." (A.R. 431)
12 She agreed to contact her doctor to discuss some counseling. Her
13 discharge diagnosis was depressive disorder, not otherwise
14 specified; rule out substance or opiate abuse; rule out substance-
15 induced depressive disorder. (*Id.*)

16 On February 22, 2010, PA Macdonald called Paulson, noting she
17 had not had a post-hospitalization followup yet. Paulson stated
18 she was taking four tablets of oxycodone every four hours, together
19 with Ibuprofen, and she was "not sleeping at all," because whenever
20 she turned over, she had too much pain to sleep. (A.R. 412)
21 PA Macdonald stated it would not be advisable for Paulson to go
22 back to using morphine because "it did not seem to help much and
23 made her thinking less clear." (A.R. 413) She directed Paulson to
24 continue taking oxycodone 20 mg every four hours, and she added
25 Remeron for the nighttime. (*Id.*)

26 Paulson was scheduled for a psychiatric followup on
27 February 25, 2010. However, on March 1, 2010, Paulson sent PA
28 Macdonald the following e-mail:

20 - FINDINGS & RECOMMENDATION

1 Dear doctor Dori: I have tried the Remeron
2 that you prescribed for me, however I have
3 even tried taking 2 at night time and it is
4 not helping me at all. Please is there
5 something else we can try? Also, I am having
6 severe muscle spasms and I am wondering if you
7 could please prescribe me something for it?
8 We just got our 2nd vehicle running again so I
9 will call and make an appoint[ment] with [the
10 psychiatrist] tomorrow, I have not seen her as
11 of yet. I am doing ok and hanging in there
12 but I am in such pain with just using the
13 Oxycodone. Please let me know about the 2
14 medicines above so that I can come in and pick
15 them up as soon as you prescribe me something.

9 (A.R. 410) On March 3, 2010, PA Macdonald responded, advising
10 Paulson to continue taking two Remeron at night, noting it would
11 take some time for the medication to become effective, and Paulson
12 should "hang in there for a month - using it every night." (*Id.*)

13 On March 4, 2010, Paulson failed to show up for her psychiatry
14 intake appointment. Paulson called the clinic on March 5, 2010, to
15 report that she had missed the appointment "due to being in too
16 much pain." (A.R. 407) On March 8, 2010, PA Macdonald sent
17 Paulson an e-mail, encouraging her to "Hang in there with the two
18 Remeron," and stating, "I expect that you will reschedule your
19 Mental Health Appointment soon - You need to get some perspective
20 as to how depression is NOT helping your [l]physical health."

21 (A.R. 411) The appointment was rescheduled for March 17, 2010.

22 (A.R. 407)

23 On March 12, 2010, Paulson received a narcotic injection to
24 treat her complaint of severe left shoulder and upper back pain.

25 (A.R. 400-01) Paulson saw PA Macdonald again on March 14, 2010,
26 complaining of pain in her left shoulder. Paulson stated it felt
27 like she had "a pinched nerve - intense pain," and she could barely
28 move it at all without pain. (A.R. 402) She was tender to

1 palpation over the shoulder, and muscle spasms were observed. She
2 was given a "rescue" treatment and was put back on Morphine, with
3 a plan to reduce her oxycodone dosage. PA Macdonald noted that if
4 Paulson did not attend her mental health appointment, she would be
5 titrated off her pain medications. (A.R. 403)

6 On March 17, 2010, Paulson saw Melinda J. Sherman, a
7 Psychiatric Mental Health Nurse Practitioner, for an intake
8 appointment and mental status evaluation. (A.R. 395-99) Paulson's
9 diagnoses were listed as "Chronic nonmalignant pain," and "Mood
10 disorder . . . due to chronic pain; reduce[d] functioning and
11 quality of life." (A.R. 395) Paulson stated her chief complaint
12 as follows: "I need my providers to give me definate [sic] answers
13 to what is wrong with me. I don't need to be talked down to or
14 lectured by my providers when I am trying my best." (*Id.*) Paulson
15 stated she had no mental health issues "prior to experiencing and
16 having to learn to live with chronic pain." (*Id.*) She stated pain
17 severely impacted her functional abilities and quality of life.
18 She stated she used to enjoy working, and she used to enjoy deep
19 sea fishing and other outdoor activities, but she was no longer
20 able to do any of these things due to pain. She indicated her days
21 now were spent "chasing her pain and dreading nights." (A.R. 395-
22 96) She would begin developing anxiety in the afternoon in
23 anticipation of "having another night of toughing it out." (A.R.
24 396) She described herself as "very sleep deprived," noting
25 shoulder pain would awaken her whenever she moved in bed. (*Id.*)

26 Paulson stated her suicide attempt was precipitated by the way
27 she was treated when she tried to reach the pain clinic for a
28 refill of her morphine. "She reports that she did not know that it

1 was a narcotic and that she could not stop it abruptly. She . . .
2 could not afford the refill any sooner and that is why she waited
3 so long." (*Id.*) She reported current primary stressors including
4 chronic pain, not knowing definitively what was wrong with her, and
5 financial strain due to not working for two years and supporting
6 her daughter and grandson. (*Id.*) She also was concerned about
7 newly-developing pain in her opposite shoulder. (A.R. 398)
8 NP Sherman considered Paulson to be a low risk for suicide or self
9 harm. (A.R. 397) She started Paulson on a trial of Effexor for
10 depression, and a trial of Temazepam for insomnia, discontinuing
11 the Remeron and Prozac. (A.R. 398-99)

12 Paulson saw PA Macdonald again on March 18, 2010. Paulson's
13 diagnoses at this visit were noted as insomnia, and arthralgia of
14 right shoulder. She stated her pain was "ever so slightly im-
15 proved" since restarting the morphine. She also felt better after
16 only one day of the Effexor. PA Macdonald recommended physical
17 therapy for Paulson's shoulder pain, but Paulson stated she could
18 not afford the treatments, which were \$125 each, so she declined
19 the referral. (A.R. 393-94) PA Macdonald recommended Paulson
20 learn an exercise program to improve her pain. She noted this
21 would be a slow process, "like crawling slowly out of a 'big
22 hole.'" (*Id.*)

23 On March 25, 2010, Paulson stated she still was not sleeping
24 at night due to muscle spasms. Regarding her chronic coccyx pain,
25 she stated it was "barely managed at all." (A.R. 408)
26 PA Macdonald indicated she had hoped Paulson's pain could be
27 managed solely with oral oxycodone, but Paulson now was indicating
28 she thought maybe the morphine did help, after all.

1 Paulson spoke by telephone with NP Sherman on April 13, 2010,
2 for followup. Paulson stated she was sleeping better with the
3 Temazepam. She also had restarted the Remeron, taking both
4 medications on an empty stomach before going to bed. She stated
5 that on this regimen, she was sleeping through the night most of
6 the time. Her physical symptoms were also somewhat improved on her
7 new medications, and she was using less morphine as a result. She
8 reported still being depressed, spending a lot of time in her room,
9 ruminating "about her financial stress and her daughter living with
10 them." (A.R. 391) She was directed to follow up in four to six
11 weeks, calling as needed in the meantime. (*Id.*)

12 A Kaiser pharmacist entered a progress note regarding Paulson
13 on May 3, 2010, apparently in connection with Paulson's request for
14 a medication refill. The note states: "No. Medication was discon-
15 tinued after her visit to pain clinic (which today in the office
16 she denied that she saw them). WILL NOT RESTART BENZODIAZEPINES."
17 (A.R. 390) Her refill request for diazepam also was declined, with
18 a note stating: "If member is to restart this medication, please
19 update order." (*Id.*)

20 On May 4, 2010, Paulson called the clinic complaining of acute
21 neck pain, radiating into her left arm, unrelieved by her
22 prescribed morphine, Soma, and Ibuprofen. She was scheduled for an
23 appointment with a doctor the next day. (A.R. 387-88) On May 5,
24 2010, Paulson saw family practitioner Ritu Manocha, M.D.,
25 transferring care from PA Macdonald. Her weight was 197 pounds at
26 this time. Paulson complained of "excruciating neck [and] shoulder
27 [pain] radiating to Left arm." (A.R. 383) "Holding her arm, and
28 started to cry, states she gets this flare up and usually gets the

1 injection in the clinic which helps. She is already on Morphine
2 among others." (*Id.*) Paulson had not started physical therapy as
3 recommended by PA Macdonald. Paulson claimed she had not taken any
4 morphine that day, and she rated her pain at 10/10. On examina-
5 tion, the doctor noted "[m]inimal tenderness, focal tender point
6 over mid scapula edge on left without swelling or redness," and
7 normal shoulder range of motion. (*Id.*) The doctor gave Paulson a
8 Toradol injection, and told Paulson she needed to start physical
9 therapy. He noted a urinary drug screen should be considered ("has
10 been ordered but not done"), and possible referral to a pain
11 management specialist. (A.R. 384) He directed Paulson to follow
12 up when she was one to two weeks into her physical therapy.
13 (A.R. 384) About three hours later, Paulson reported continuing
14 shoulder pain. She stated that although she normally got relief
15 from a Toradol injection, this time the injection had not helped
16 her pain. She was given a second Toradol injection. (A.R. 380)

17 On May 6, 2010, Paulson had x-rays of her cervical spine in
18 connection with her complaints of neck and shoulder pain. The x-
19 rays showed minimal degenerative disk disease and narrowing in
20 Paulson's cervical spine, but "[n]othing acute." (A.R. 428) She
21 was directed to increase her Remeron and take Soma, both at night.

22 Paulson saw a physical therapist on May 12, 2010, for a
23 cervical spine evaluation. (A.R. 376-79) Paulson described her
24 daily activities as follows: "I do nothing. I lay in bed all the
25 time, as soon as I move the tailbone pain is worse." (A.R. 376)
26 She was on medication for her chronic tailbone pain. The reason
27 for her physical therapy referral was sharp pain in her left
28 shoulder, referring up to her neck and down the back of her arm to

1 the elbow. She also complained of tingling and numbness from the
2 front of her shoulder down to her forearm, left thumb, and pointer
3 finger. (*Id.*) Her pain was aggravated by lying on her left side,
4 and cervical rotation. She obtained some relief from injections,
5 ice, and lying propped up in bed with ice and a neck pillow. (*Id.*)

6 On examination, Paulson had some increased pain from forward
7 flexion, but the pain decreased in less than one minute. She had
8 100% extension of her neck; 30 degrees on side-bending bilaterally;
9 70 degrees of rotation on the right; and 50 degrees of rotation of
10 her posterior arm on the left. She had full ranges of motion of
11 her left shoulder, with no increase in symptoms; however, with her
12 hands behind her head, she experienced "severe pain" in her left
13 tricep, "not recreated with cervical protraction alone." (A.R.
14 377) She was treated with manual therapy and traction, which
15 decreased her pain. Paulson was noted to be "very deconditioned as
16 she lays in bed due to her pain and she has very poor posture both
17 of which are likely contributing to [her] pain." (A.R. 378) The
18 therapist noted Paulson would benefit from further physical
19 therapy, but Paulson declined "due to finances." (*Id.*) She was
20 instructed in "proper self care, posture, positioning (ie position-
21 ing in bed), . . . anatomy and importance of posture/position of
22 head." (*Id.*) She also was instructed in a home exercise program,
23 including how her husband could apply gentle traction for pain
24 relief. Paulson also was advised of the importance of regular
25 activity, and how staying in bed all day "only increases her pain,
26 [and] makes her weaker and tighter." (*Id.*)

27 On June 10, 2010, Paulson was seen for a "plugged ear." (A.R.
28 442) Dr. Manocha prescribed pseudoephedrine. (A.R. 443) He also

1 wrote another referral to physical therapy, as well as a referral
2 to Kaiser's pain management department "for Pain Group Classes."
3 (A.R. 442) He also directed Paulson to have a urine drug screen
4 that day. (*Id.*)

5 On August 2, 2010, Paulson saw Internal Medicine specialist
6 Cheryl Layne, M.D., apparently for purposes of completing a new
7 Complex Opioid Therapy Plan. (A.R. 460) Although Paulson
8 initialed the form in several places, the form is not signed at the
9 end. (A.R. 463-66) On August 20, 2010, Dr. Layne signed a
10 Certificate of Disability form in connection with Paulson's
11 application for a Disabled Person Parking Permit. (A.R. 454-55)

12 Paulson received an epidural steroid injection from pain
13 management specialist Suzanne C. Zarling, M.D. on August 13, 2010.
14 Paulson also received a prescription for Lidocaine patches. (A.R.
15 456-58)

16
17 ***B. Vocational Expert's Testimony***

18 At the VE's request, because the record does not contain a
19 work history report, Paulson testified in some detail about her
20 past work. (See A.R. 62-63) In 2000, she worked as a customer
21 service account manager for an Internet Service Provider. Her
22 duties included accepting payments from customers, helping
23 customers "troubleshoot if they were having problems," and
24 transferring them to a technical specialist if necessary. (A.R.
25 63-65) She had to learn a great deal about how the internet
26 service worked, and stated, "That's why it's so hard to be in the
27 position I am now, is because I was such a go-getter and you know,
28 I have had thoughts of suicide, you know, because of being such a

1 go-getter and working so many years." (A.R. 65) The VE indicated
 2 the clerical part of this job "is probably best described as a
 3 cashier one." (A.R. 67) He stated this is a sedentary, skilled
 4 job at the SVP-5 level.⁶ (*Id.*) The VE further stated "there's a
 5 title called user support analyst, which it's an SVP-7 and
 6 sedentary[.] [S]he probably didn't work at the SVP-7 level but her
 7 testimony is she did learn most of the things that were needed at
 8 the time. That's a job, obviously, that changes rapidly so any
 9 skill she learned five, six, 10 years ago would not be real
 10 applicable today." (*Id.*)

11 Paulson also worked for a printing company, taking orders for
 12 classified ads in the newspaper, typing while she talked on the
 13 phone. (A.R. 65-66) The VE identified this job as an "advertising
 14 clerk, SVP-4 and sedentary." (A.R. 67)

15 Paulson worked in retail sales for J.C. Penney, which required
 16 her to be on her feet all day. (A.R. 66) The VE identified this
 17 job as "retail sales clerk, SVP-3 and light." (A.R. 67)

18 She also worked at a customer service job on the phone,
 19 calling publishers "to see what books were published, because
 20 libraries and universities all over the world would want to know if
 21

22 ⁶The "SVP" refers to the level of "specific vocational prepa-
 23 ration" required to perform certain jobs, according to the
 24 *Dictionary of Occupational Titles*. The SVP "is defined as the
 25 amount of lapsed time required by a typical worker to learn the
 26 techniques, acquire the information, and develop the facility
 27 needed for average performance in a specific job-worker situation."
 28 *Davis v. Astrue*, slip op., 2011 WL 6152870, at *9 n.7 (D. Or.
 Dec. 7, 2011) (Simon, J.) (citation omitted). "The DOT identifies
 jobs with an SVP level of 1 or 2 as unskilled, jobs with an SVP of
 3 or 4 as semi-skilled, and jobs with an SVP of 5 or higher as
 skilled." *Whitney v. Astrue*, slip op., 2012 WL 712985, at 3 (D. Or.
 Mar. 1, 2012) (Brown, J.) (citing SSR 00-4p).

1 those books were published yet so that they could order from the
2 publisher." (A.R. 66-67) The VE identified this job as "customer-
3 service clerk SVP-4 and light although it's done posturally in a
4 sedentary position in most environments." (A.R. 67-68)

5 In her most recent job, Paulson worked as a receptionist at LG
6 International. Her duties included answering the phone, helping
7 make labels and buttons in the shop, and sometimes lifting heavy
8 boxes. She was laid off in May 2008, but stated she would not have
9 been able to continue working even if she had not been laid off.
10 She stated had been missing a lot of work prior to the layoff.

11 (A.R. 40-42) The VE described this job as follows:

12 That's an SVP-4 and sedentary. To the extent
13 that she did production assembly, that's
14 unskilled and light. And she described moving
15 boxes in a warehouse kind of environment.
16 That would be a material handler, SVP-3 and
the DOT calls it heavy because again, it's an
omnibus title and covers everything. She
probably was not working at a heavy level,
would be possibly medium.

17 (A.R. 68)

18 The ALJ asked the VE the following question:

19 If we had an individual with age, education,
20 and work experience similar to that of the
claimant who is capable of lifting 10 pounds
occasionally, less than 10 pounds frequently,
21 was limited to occasional overhead reaching
with the right arm, restricted to simple
22 routine work and needs to be able to sit or
stand in the performance of the work - so the
23 simple routine work would rule out at least
the ones with SVP-4 and above, certainly - and
24 the sales clerk was a light job, so it rules
that out, and the material handler was a
25 heavy- or medium-as-performed job, and so
that's ruled out. So I don't see any past
26 relevant work that can be done within this
RFC, do you?

27
28 (A.R. 69)

29 - FINDINGS & RECOMMENDATION

1 The VE agreed that a person with those limitations could not
2 do any of Paulson's past relevant work. (*Id.*) The VE indicated
3 the hypothetical individual could perform some jobs in the national
4 economy, but "[n]ot very many." (*Id.*) The VE indicated "[t]here
5 would be a few sit-stand jobs that would be predominantly in the
6 cashiering field, but certainly not the whole range of cashiers.
7 Some assembly jobs, some hand-packaging jobs, but their numbers are
8 not very large." (*Id.*) The VE estimated there would be no more
9 than 3,000 Cashier II category jobs in Oregon; no more than 7,000
10 in Washington; and no more than 300,000 nationally. Cashier II
11 jobs normally have a sit-stand option, and they are defined as
12 light in the DOT. (A.R. 70)

13 As to small product assembly jobs at the sedentary level, with
14 a sit-stand option, the VE estimated there would be about 1,200 in
15 Washington, and perhaps 100,000 nationally. (*Id.*)

16 Regarding the hand packaging jobs, he estimated there would be
17 no more than 90,000 nationally, and no more than 1,000 in
18 Washington. (A.R. 70) He explained that the sedentary hand
19 packaging jobs "are primarily in produce packing, candy packaging,
20 nuts packaging, small items like that." (A.R. 71-72)

21 The VE stated if the individual required breaks beyond those
22 normally available ("a morning break, an afternoon break, and a 30-
23 minute to an hour lunch break"), for purposes of lying down for
24 thirty minutes, there would not be any jobs available for the
25 individual. (A.R. 70-71) Similarly, if an individual had to miss
26 more than four days of work per month, the individual likely would
27 be unable to sustain competitive employment. (A.R. 72-73) In
28 addition, in "a vast majority" of cases, an individual probably

1 could not sustain employment in a job with production quotas, if
2 the individual could only be 60 to 70 percent as productive as
3 other average workers due to medication side effects and/or
4 impairments, whether physical or mental. (A.R. 73)

5
6 ***C. Paulson's Hearing Testimony***

7 Paulson stated she is "in bed all day long." (A.R. 43) She
8 lives with her husband, 24-year-old daughter, and 5-year-old
9 grandson. Her daughter stays home and takes care of Paulson.
10 (A.R. 43-44)

11 Paulson stated she has had pain for about eight years, with
12 the pain getting worse during that time. She does not believe she
13 can work, even with a sit-stand option, no substantial lifting, and
14 fairly simple and routine tasks. She stated:

15 As I've even tried to cook dinner, I can't
16 handle even making a dinner, so I know even at
17 home I can't withstand standing for a very
18 long time, or sitting for a very long time.
19 And as my doctor has explained to me, once I
20 stand up and I get my legs in motion, that's
21 what starts my tailbone and that inflammation
22 to start working up again, and starts the
process of getting it inflamed again and
continuing the inflammation to get stronger.
So all I can say is that all I can do is lay.
That's the only time I'm comfortable is when I
can lay in bed. And even then I'm in pain,
when I'm laying down.

23 (A.R. 44) She estimated she can sit and stand, each, for no more
24 than ten to fifteen minutes before she becomes uncomfortable and
25 needs to change position. (A.R. 46-47) She stated she can only
26 walk about "20 steps" before she needs to rest. Noting Paulson had
27 not used a wheelchair to get to the hearing, the ALJ asked if she
28 had to "stop and rest every 20 feet[.]" Paulson replied, "No, I

1 didn't. I made myself." (A.R. 47-48) She has difficulty lifting,
2 and cannot lift a gallon of milk. (A.R. 48)

3 Paulson stated she takes morphine and Oxycontin on a regular
4 basis. The ALJ observed that Paulson appeared "very coherent and
5 wide awake for having been up taking those medicines." (A.R. 45)
6 Paulson stated she suffers side effects from the medications
7 including "a lot of depression," and problems with memory and
8 concentration. (A.R. 46) She stated her pain is constant. When
9 she is on her medications, the pain normally is about a 5 on a 10-
10 point scale. If she forgets to take a dose, the pain goes "right
11 back up to an eight." (*Id.*)

12 Paulson indicated she has a migraine headache about once a
13 month, on average. The headaches average about four hours in
14 duration, during which she has to lie down. During a migraine
15 headache, her pain level is at 10/10. She will be "throwing up and
16 stuff," and have visual problems ("the aura"). (A.R. 49) She
17 sometimes can tell when a migraine is coming on, and she will take
18 medication that shortens the duration of the headache. (*Id.*)

19 Paulson also has pain in her shoulders, primarily her right
20 shoulder and right side of her neck. She has pain when she moves
21 the shoulder, and is limited in how high she can lift her arm. She
22 can reach upward, but cannot extend her arm all the way. She can
23 reach out in front of her and to the side, but cannot reach back
24 behind her with her right arm. (A.R. 50-51) On an average day,
25 her shoulder pain is at a level of about 5/10. She has a TENS
26 machine that helps somewhat, and she uses it at least twice a day.
27 (A.R. 52-53) The shoulder pain interferes with her sleep because
28 when she rolls over, "it turns into shooting pains and then it's

1 just that excruciating, sharp pain," waking her up. (A.R. 53) She
2 stated she is awakened by pain "at least four times during the
3 night." (*Id.*) She usually gets about five hours of sleep during
4 the night, and she also takes two naps during the day, one from
5 about 9:00 to 10:30 in the morning, and the other from about 2:00
6 to 3:30 in the afternoon. (A.R. 53-54)

7 Regarding her depression, Paulson acknowledged that her
8 doctors have recommended she see a counselor, "but the problem is
9 money." (A.R. 54) She stated, "We can only do so much with living
10 off my husband's income." (*Id.*)

11 Paulson stated her husband and daughter do the household
12 chores. Up until about three months prior to the ALJ hearing,
13 Paulson had been able to help with making her bed, and doing
14 minimal grocery shopping, but she stated that within the preceding
15 two or three months, her "back and everything's gotten really bad."
16 (A.R. 55) Even before that time, however, she could only go to the
17 grocery store for about thirty minutes, and making the bed was
18 painful for her. (*Id.*)

19 20 **D. Third-Party Testimony**

21 Paulson's husband Charles testified briefly at the ALJ
22 hearing. He stated he and his wife have been married for twenty-
23 six years. He works full time, and on an average day, he spends
24 from 4:00 p.m. to 7:00 a.m. at home with his wife. (A.R. 57-58)
25 He has observed that Paulson struggles with memory and concentra-
26 tion. He stated, "She gets confused. Different things that we've
27 discussed, and during the course of a week, planning for bills,
28 things that we just discussed financially, and also that she just

1 can't remember just in a short period of time what we've discussed.
2 She blanks totally out." (A.R. 58) In his opinion, it is "mainly
3 short-term" memory that causes Paulson problems. (*Id.*) He had
4 noticed the problem worsening over the previous couple of years.
5 He stated when he and Paulson are having a short conversation, "she
6 will pause in it, and it's like her mind wanders off and she's just
7 not concentrating." (A.R. 59) However, if she gets involved in a
8 television show, she is able to track along with it for half an
9 hour. (*Id.*)

10 According to Charles, before Paulson got laid off from work,
11 she was "doing a good job, but she had to start taking the heating
12 pad to work, sitting on that on a daily basis. Her back started to
13 get really sore, and she was unable to sit for a long period of
14 time." (A.R. 59) He agreed with Paulson's statement that her pain
15 had gotten worse over the previous two or three months, and she was
16 no longer able to help with any of the housework. (A.R. 59-60)

17 Charles stated his wife hates having to lie around all the
18 time. He stated she used to be "outgoing and just enjoyed life."
19 (A.R. 61) He indicated he and his wife would like to know what is
20 wrong with her, stating she has seen specialists, and they are
21 doing everything they can to find the cause of her pain. (A.R. 60,
22 61)

23 Charles also completed a written third-party Function Report.
24 (A.R. 172-79) He indicated Paulson stays in bed all day until he
25 gets home from work. Paulson used to be able to work at a job, do
26 housework, and enjoy golf, fishing, camping, and shopping, but she
27 is no longer able to do these things. He indicated pain keeps
28 Paulson awake at night. She has no problems with her personal

1 care, but is unable to do household chores or yard work.

2 (A.R. 172-74) He stated, "She is in severe pain always she has to
3 be on her heating pad in bed to find relief and lots of medicine."

4 (A.R. 175) Charles stated his wife goes out about once every two
5 weeks. She sometimes drives, but "sometimes she can't go alone
6 because of all of the medication she is on," so he will drive.

7 (*Id.*) She might go grocery shopping with Charles a couple of times
8 a month, but she shops for clothing and medicines by phone and
9 computer. (*Id.*) According to Charles, he and his wife used to be

10 very sociable and "on the go always." (A.R. 176) Now they go to
11 bed at 9:00 p.m. He indicated they go to a restaurant maybe once
12 every six months. (*Id.*)

13 Charles listed his estimates of Paulson's functional
14 abilities. He estimated she can lift "maybe 5 lbs"; she cannot
15 bend as far or long as she used to; she can stand for five minutes;
16 "reaching hurts, walking hurts, sitting hurts, kneeling hurts,
17 stair climbing - hurts, memory - forgets often, complete tasks -
18 starts something [and] can't finish, concentration - hurts." (A.R.
19 177) According to him, Paulson can only walk "a few feet" before
20 having to stop and rest for "at least a while." (*Id.*) He
21 indicated Paulson has a hard time getting comfortable, and "she is
22 always crying a lot [and] wondering why this has happened to her so
23 young[.]" (A.R. 178)

24 25 **III. DISABILITY DETERMINATION AND THE BURDEN OF PROOF**

26 **A. Legal Standards**

27 A claimant is disabled if he or she is unable to "engage in
28 any substantial gainful activity by reason of any medically

determinable physical or mental impairment which . . . has lasted or can be expected to last for a continuous period of not less than 12 months[.]” 42 U.S.C. § 423(d)(1)(A).

“Social Security Regulations set out a five-step sequential process for determining whether an applicant is disabled within the meaning of the Social Security Act.” *Keyser v. Commissioner*, 648 F.3d 721, 724 (9th Cir. 2011) (citing 20 C.F.R. § 404.1520). The *Keyser* court described the five steps in the process as follows:

(1) Is the claimant presently working in a substantially gainful activity? (2) Is the claimant’s impairment severe? (3) Does the impairment meet or equal one of a list of specific impairments described in the regulations? (4) Is the claimant able to perform any work that he or she has done in the past? and (5) Are there significant numbers of jobs in the national economy that the claimant can perform?

Keyser, 648 F.3d at 724-25 (citing *Tackett v. Apfel*, 180 F.3d 1094, 1098-99 (9th Cir. 1999)); see *Bustamante v. Massanari*, 262 F.3d 949, 953-54 (9th Cir. 2001) (citing 20 C.F.R. §§ 404.1520 (b)-(f) and 416.920 (b)-(f)). The claimant bears the burden of proof for the first four steps in the process. If the claimant fails to meet the burden at any of those four steps, then the claimant is not disabled. *Bustamante*, 262 F.3d at 953-54; see *Bowen v. Yuckert*, 482 U.S. 137, 140-41, 107 S. Ct. 2287, 2291, 96 L. Ed. 2d 119 (1987); 20 C.F.R. §§ 404.1520(g) and 416.920(g) (setting forth general standards for evaluating disability), 404.1566 and 416.966 (describing “work which exists in the national economy”), and 416.960(c) (discussing how a claimant’s vocational background figures into the disability determination).

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1 The Commissioner bears the burden of proof at step five of the
2 process, where the Commissioner must show the claimant can perform
3 other work that exists in significant numbers in the national
4 economy, "taking into consideration the claimant's residual
5 functional capacity, age, education, and work experience." *Tackett*
6 *v. Apfel*, 180 F.3d 1094, 1100 (9th Cir. 1999). If the Commissioner
7 fails meet this burden, then the claimant is disabled, but if the
8 Commissioner proves the claimant is able to perform other work
9 which exists in the national economy, then the claimant is not
10 disabled. *Bustamante*, 262 F.3d at 954 (citing 20 C.F.R.
11 §§ 404.1520(f), 416.920(f); *Tackett*, 180 F.3d at 1098-99).

12 The ALJ determines the credibility of the medical testimony
13 and also resolves any conflicts in the evidence. *Batson v. Comm'r*
14 *of Soc. Sec. Admin.*, 359 F.3d 1190, 1196 (9th Cir. 2004) (citing
15 *Matney v. Sullivan*, 981 F.2d 1016, 1019 (9th Cir. 1992)).
16 Ordinarily, the ALJ must give greater weight to the opinions of
17 treating physicians, but the ALJ may disregard treating physicians'
18 opinions where they are "conclusory, brief, and unsupported by the
19 record as a whole, . . . or by objective medical findings." *Id.*
20 (citing *Matney, supra*; *Tonapetyan v. Halter*, 242 F.3d 1144, 1149
21 (9th Cir. 2001)). If the ALJ disregards a treating physician's
22 opinions, "'the ALJ must give specific, legitimate reasons'" for
23 doing so. *Id.* (quoting *Matney*).

24 The law regarding the weight to be given to the opinions of
25 treating physicians is well established. "The opinions of treating
26 physicians are given greater weight than those of examining but
27 non-treating physicians or physicians who only review the record."
28 *Benton ex rel. Benton v. Barnhart*, 331 F.3d 1030, 1036 (9th Cir.

2003). The *Benton* court quoted with approval from *Lester v. Chater*, 81 F.3d 821, 830 (9th Cir. 1995), where the court held as follows:

As a general rule, more weight should be given to the opinion of a treating source than to the opinion of doctors who do not treat the claimant. At least where the treating doctor's opinion is not contradicted by another doctor, it may be rejected only for "clear and convincing" reasons. We have also held that "clear and convincing" reasons are required to reject the treating doctor's ultimate conclusions. Even if the treating doctor's opinion is contradicted by another doctor, the Commissioner may not reject this opinion without providing "specific and legitimate reasons" supported by substantial evidence in the record for so doing.

Id. (quoting *Lester, supra*).

The ALJ also determines the credibility of the claimant's testimony regarding his or her symptoms:

In deciding whether to admit a claimant's subjective symptom testimony, the ALJ must engage in a two-step analysis. *Smolen v. Chater*, 80 F.3d 1273, 1281 (9th Cir. 1996). Under the first step prescribed by *Smolen*, . . . the claimant must produce objective medical evidence of underlying "impairment," and must show that the impairment, or a combination of impairments, "could reasonably be expected to produce pain or other symptoms." *Id.* at 1281-82. If this . . . test is satisfied, and if the ALJ's credibility analysis of the claimant's testimony shows no malingering, then the ALJ may reject the claimant's testimony about severity of symptoms [only] with "specific findings stating clear and convincing reasons for doing so." *Id.* at 1284.

Batson, 359 F.3d at 1196.

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1 **B. The ALJ's Decision**

2 The ALJ found Paulson was insured for purposes of a Title II
3 claim through December 31, 2012. She therefore "must establish
4 disability on or before that date in order to be entitled to a
5 period of disability and disability insurance benefits." (A.R. 18)
6 He found Paulson has not engaged in substantial gainful activity
7 since her alleged onset date of May 28, 2008. (A.R. 20)

8 The ALJ found Paulson has severe impairments consisting of
9 "obesity, chronic severe constipation, chronic narcotic use,
10 degenerative disc disease of the lumbar spine, depression, chronic
11 pain, and migraine headaches." (*Id.*) However, he further found
12 that none of these, singly or in combination, meets or medically
13 equals any of the impairments listed in the regulations. (*Id.*)
14 Specifically with regard to Paulson's degenerative disc disease of
15 the cervical spine, the ALJ noted the Record contains "no evidence
16 of nerve root compression characterized by neuro-anatomic distri-
17 bution of pain, limitation of motion of the spine, [or] motor loss
18 (atrophy with associated muscle weakness or muscle weakness)
19 accompanied by sensory or reflect loss[,] and the impairment
20 therefore does not meet Listing 1.04. (A.R. 21) He further noted,
21 "As there are no Listings for obesity or chronic pain, these
22 impairments have been factored into the assessment of [Paulson's]
23 other impairments and their relationships to the requirements of
24 the Listings." (*Id.*) He found Paulson's "headaches do not meet or
25 equal the Listings at 12.02 and 12.03 and [her] chronic constipa-
26 tion does not meet or equal any Listing found at 5.00." (*Id.*)

27 The ALJ further found that none of the other conditions for
28 which Paulson has been treated, or of which she has complained, are

1 severe, including nicotine dependence, aortic valve regurgitation,
2 ovarian cysts, insomnia, right arm and shoulder pain, and neck
3 pain. He found "these alleged impairments, considered singly or
4 together, have caused only transient and mild symptoms and
5 limitations, are well controlled with treatment, or are otherwise
6 not adequately supported by the medical evidence in the record."
7 (*Id.*)

8 Regarding Paulson's mental impairments, the ALJ found her
9 "depression and her chronic pain medication use do not meet or
10 medically equal the criteria of Listings 12.04 or 12.09." (*Id.*)
11 He found Paulson has mild restriction in her activities of daily
12 living and social functioning; moderate difficulties with regard to
13 concentration, persistence, or pace; and no episodes of decom-
14 pensation of extended duration. (*Id.*)

15 The ALJ found Paulson has the residual functional capacity
16 ("RFC") to perform sedentary work, with limitations of lifting up
17 to ten pounds occasionally and less than ten pounds frequently;
18 only occasional overhead reaching with her right arm; the ability
19 to sit or stand as needed while she is working; and restriction to
20 simple, routine work. (A.R. 22) In reaching this conclusion, the
21 ALJ found Paulson's allegations regarding the intensity,
22 persistence, and limiting effects of her symptoms are not fully
23 credible, to the extent they are inconsistent with the above RFC.
24 (*Id.*)

25 In support of his credibility finding, the ALJ noted the
26 record evidence indicates Paulson's "symptoms have not worsened
27 since 2006, and . . . she was able to work up until May 2008 in
28 spite of her symptoms." (A.R. 23) The ALJ noted Paulson's medical

1 records indicate her "symptoms are grossly disproportionate to the
2 objective and clinical findings." (*Id.*) He noted Paulson
3 complains of severe sacral and coccyx pain, but MRIs of those areas
4 show no abnormality that would account for her pain. X-rays in May
5 2008 of her lumbar spine were normal, and a July 2008 bone scan
6 also showed no abnormalities. Although an MRI in August 2008,
7 showed some "mild multilevel degenerative changes within the lumbar
8 spine," there was "no advanced stenoses or definite neural
9 impingement." (A.R. 24)

10 Regarding Paulson's "depression, and complaints of fatigue,
11 memory and concentration problems," the ALJ noted Paulson has never
12 "received or sought mental health counseling, nor does the record
13 show [she] has ever been referred for mental health counseling by
14 any of her medical providers."⁷ (*Id.*)

15 The ALJ "assigned some weight" to the testimony of Paulson's
16 husband, noting "[h]is statements are considered credible to the
17 extent that he has accurately reported what he has seen, what has
18 been exhibited to him, and what he has been told." (A.R. 24)
19 However, the ALJ further noted that although Mr. Paulson's testi-
20 mony was "credible, behavior exhibited or symptoms reported by a
21 subject are not an adequate basis to establish disability." (*Id.*)
22 The ALJ found more persuasive "the opinions from medical
23
24

25 ⁷As noted above in the medical summary, Paulson's doctors
26 recommended counseling after her suicide attempt which post-dated
27 the ALJ's decision. The Appeals Council considered Paulson's
28 medical records post-dating the ALJ hearing, which included the
records from, and subsequent to, her suicide attempt, but "found
that this information does not provide a basis for changing the
[ALJ's] decision." (A.R. 1-2, 4)

1 professionals who are trained to evaluate impairments and their
2 impact on functional capacity." (A.R. 24-25)

3 The ALJ gave "some weight" to the opinions of the consulting
4 physicians, Drs. Anderson and Nicoloff, who opined Paulson's
5 depression was related to her chronic pain, and had not prevented
6 her from working in the past. However, the ALJ found Paulson's
7 "depression, in addition to the side effects from her heavy
8 medications, limit her to simple, routine work." (A.R. 25)

9 Regarding Paulson's physical functional abilities, the ALJ gave
10 "great weight" to the opinions of consulting doctors Westfall and
11 Kehrli, who opined Paulson would be able to perform light work.
12 However, the ALJ gave Paulson "the full benefit of the doubt
13 regarding her allegations of lower back and upper extremity pain,"
14 and therefore limited Paulson "to sedentary exertion activities."
15 (*Id.*)

16 The ALJ gave PA Macdonald's opinion regarding Paulson's
17 functional abilities "a small amount of weight." (A.R. 26) He
18 noted PA Macdonald acknowledged that "she is not trained to
19 complete the 'tests of functional capacity.'" (*Id.*) He further
20 found the objective evidence of record "does not show that
21 [Paulson's] pain has resulted in any muscle weakness, as
22 Ms. Macdonald reports," and "treatment records simply do not reveal
23 the type of significant clinical and laboratory findings that one
24 would expect to find to support a finding of total disability."
25 (*Id.*)

26 The ALJ noted Paulson's medical records, which begin about two
27 years before her alleged onset date, show her symptoms of pain and
28 depression have not worsened progressively over the years, and she

1 continued to work in spite of her symptoms. Paulson has been on
2 "heavy narcotic pain medications at least since 2006." (*Id.*)
3 Paulson consistently rated her pain at 8/10 to her treating
4 sources, yet "this pain level did not preclude her from working in
5 the past," or from caring for her grandson. (*Id.*) The ALJ
6 acknowledged that Paulson's husband testified Paulson was per-
7 forming well at work, although by the time the job ended, she was
8 taking a heating pad to sit on to relieve discomfort due to
9 sitting. However, the ALJ further noted Paulson's last job did not
10 end due to her medical conditions, but due to a layoff. (*Id.*)

11 The ALJ noted Paulson has received generally conservative
12 treatment for her pain and depression. Even though the ALJ did not
13 find objective evidence in the record to explain Paulson's right
14 arm and shoulder pain, he nevertheless "accord[ed] her the full
15 benefit of the doubt," and reduced her RFC accordingly. (A.R. 27)

16 Based on his RFC finding, the ALJ concluded Paulson is unable
17 to perform any of her past relevant work. However, relying on the
18 VE's testimony, the ALJ found Paulson is able to perform other jobs
19 that exist in significant numbers in the national economy. Even
20 though she cannot perform the full range of sedentary work, she
21 still could perform the requirements of representative occupations
22 such as cashier II (which the *DOT* classifies as unskilled, light
23 work, but the VE, in his "expert opinion," classified as
24 sedentary); product assembler; and hand packager. (A.R. 28) The
25 ALJ therefore concluded Paulson was not disabled from May 28, 2008,
26 through the date of his decision. (*Id.*)

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28 / / /

IV. STANDARD OF REVIEW

The court may set aside a denial of benefits only if the Commissioner's findings are "not supported by substantial evidence or [are] based on legal error.'" *Bray v. Comm'r of Soc. Sec. Admin.*, 554 F.3d 1219, 1222 (9th Cir. 2009) (quoting *Robbins v. Soc. Sec. Admin.*, 466 F.3d 880, 882 (9th Cir. 2006)); accord *Black V. Comm'r of Soc. Sec. Admin.*, slip op., 2011 WL 1930418, at *1 (9th Cir. May 20, 2011). Substantial evidence is "more than a mere scintilla but less than a preponderance; it is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.'" *Id.* (quoting *Andrews v. Shalala*, 53 F.3d 1035, 1039 (9th Cir. 1995)).

The court "cannot affirm the Commissioner's decision 'simply by isolating a specific quantum of supporting evidence.'" *Holohan v. Massanari*, 246 F.3d 1195, 1201 (9th Cir. 2001) (quoting *Tackett v. Apfel*, 180 F.3d 1094, 1097 (9th Cir. 1998)). Instead, the court must consider the entire record, weighing both the evidence that supports the Commissioner's conclusions, and the evidence that detracts from those conclusions. *Id.* However, if the evidence as a whole can support more than one rational interpretation, the ALJ's decision must be upheld; the court may not substitute its judgment for the ALJ's. *Bray*, 554 F.3d at 1222 (citing *Massachi v. Astrue*, 486 F.3d 1149, 1152 (9th Cir. 2007)).

V. DISCUSSION

Paulson argues the ALJ erred in finding her complaints not to be fully credible, not giving her husband's testimony greater weight, and rejecting the opinions of her treating and examining

sources. Dkt. #19. The Commissioner disagrees, arguing substantial evidence supports the ALJ's findings. Dkt. #21.

A. ALJ's Credibility Finding

Paulson argues the ALJ improperly rejected her subject complaints, finding them to be less than fully credible. She argues the ALJ failed to comply with the requirements of Social Security Ruling (SSR) 96-7p, and applicable case law. Dkt. #19, pp. 6-9.

The Ninth Circuit Court of Appeals repeatedly has explained the requirements for an ALJ to reject a claimant's testimony regarding the severity of her symptoms. Once the claimant has produced objective medical evidence which reasonably could be expected to produce "some level of symptoms," and as long as there is no evidence of malingering, the "ALJ can reject the claimant's testimony about the severity of her symptoms only by offering specific, clear and convincing reasons for doing so." *Murray v. Apfel*, 210 F.3d 384 (Table), 2000 WL 5936 at *1 (9th Cir. Jan. 4, 2000) (quoting *Smolen v. Chater*, 80 F.3d 1273, 1281 (9th Cir. 1996); citing *Dodrill v. Shalala*, 12 F.3d 915, 918 (9th Cir. 1993) (same)). It is legal error for an ALJ to discredit a claimant's testimony about the intensity and persistence of pain or other symptoms, or the limitations caused by those symptoms, solely for lack of supporting objective medical evidence. *Hubble v. SSA*, 290 Fed. Appx. 56, 2008 WL 3307144 at *1 (9th Cir. July 17, 2008) (citing *Cotton v. Bowen*, 799 F.2d 1403 (9th Cir. 1986), superseded by statute on other grounds as stated in *Bunnell v. Sullivan*, 912 F.2d 1149 (9th Cir. 1990)); see also SSR 96-7p, 1996 WL 374186 at

*1. SSR 96-7p, cited by Paulson, similarly requires the ALJ to cite "specific reasons for the finding on credibility, supported by the evidence in the case record, and . . . sufficiently specific to make clear to the individual and to any subsequent reviewers the weight the [ALJ] gave to the individual's statements and the reasons for that weight." SSR 96-7p, 1996 WL 374186.

Paulson argues she has met the *Cotton* requirements, which the Ninth Circuit has described as "(1) producing objective evidence of an impairment; and (2) demonstrating that the impairment could reasonably be expected to produce the symptoms alleged; [and] there was no evidence of malingering[.]" *Hubble*, 2008 WL 3307144 at *1 (citing *Dodrill*, 12 F.3d at 918). She argues the ALJ erred because he failed to provide the required "clear and convincing" reasons to discredit her testimony.

The ALJ found Paulson met the *Cotton* requirements; he specifically found objective evidence of her impairments, and that her "medically determinable impairments could reasonably be expected to cause some of the alleged symptoms[.]" (A.R. 22) Further, the ALJ made no finding of malingering, and he accorded "great weight" to Dr. Westfall's observation that "the fact [Paulson's] physicians keep prescribing narcotic pain medication to her lends credence to her complaints[.]" (A.R. 25) Thus, the ALJ could only reject Paulson's testimony regarding the severity of her symptoms by making "specific findings stating clear and convincing reasons for doing so." *Smolen v. Chater*, 80 F.3d 1273, 1285 (9th Cir. 1996) (citing *Dodrill v. Shalala*, 12 F.3d 915, 918 (9th Cir. 1993)). The ALJ was required to "state specifically which symptom testimony is

1 not credible and what facts in the record lead to that conclusion."
2 *Id.*

3 The ALJ reviewed Paulson's subjective complaints, and noted he
4 had reduced Paulson's RFC to accommodate limitations resulting from
5 her various impairments. He then stated, "However, the undersigned
6 cannot find the claimant's allegations that she is incapable of all
7 work activity to be credible because of the lack of objective
8 medical evidence." (A.R. 23) While SSR 96-7p directs the ALJ to
9 consider the degree to which the claimant's statements are
10 consistent with the objective medical evidence of record, the
11 Ruling specifically prohibits an ALJ from disregarding a claimant's
12 subjective complaints solely because of "the lack of objective
13 medical evidence":

14 Because symptoms, such as pain, sometimes
15 suggest a greater severity of impairment than
16 can be shown by objective medical evidence
17 alone, the adjudicator must carefully consider
18 the individual's statements about symptoms
19 with the rest of the relevant evidence in the
20 case record in reaching a conclusion about the
21 credibility of the individual's statements if
22 a disability determination or decision that is
23 fully favorable to the individual cannot be
24 made solely on the basis of objective medical
25 evidence. . . . *An individual's statements*
26 *about the intensity and persistence of pain or*
27 *other symptoms or about the effect the*
28 *symptoms have on his or her ability to work*
may not be disregarded solely because they are
not substantiated by objective medical evi-
dence.

24 SSR 96-7p, 1996 WL 374186 at *1 (emphasis added).

25 Here, however, the ALJ *did not* reject Paulson's subjective
26 testimony *solely* on the basis of the lack of objective evidence.
27 The ALJ correctly noted that subjective complaints, standing alone,
28 are not "conclusive evidence of disability." (A.R. 23) The

1 regulations specify that an impairment must be verifiable by
2 "medical evidence consisting of signs, symptoms, and laboratory
3 findings, not only by [the individual's] statement of symptoms[.]"
4 20 C.F.R. § 416.908; see A.R. 23 (citing same). Indeed, the
5 regulations require that for subjective complaints of pain and
6 other symptoms to be determinative, they must be reasonably
7 consistent with objective medical evidence. 20 C.F.R. § 416.929(a)
8 ("[S]tatements about your pain or other symptoms will not alone
9 establish that you are disabled; there must be medical signs and
10 laboratory findings which show that you have a medical impair-
11 ment(s) which could reasonably be expected to produce the pain or
12 other symptoms alleged and which, when considered with all of the
13 other evidence (including statements about the intensity and
14 persistence of your pain or other symptoms *which may reasonably be*
15 *accepted as consistent with the medical signs and laboratory*
16 *findings*), would lead to a conclusion that you are disabled."
17 Emphasis added.); see A.R. 23 (citing same).

18 The ALJ cited specific evidence to support his credibility
19 determination. He noted Paulson's symptoms, particularly her
20 coccyx pain, have been present since at least 2006, and she has
21 been treated with narcotic pain medications since that time, but
22 nevertheless, she continued to work until she was laid off in May
23 2008. Her MRI and x-ray studies over the years have failed to show
24 any remarkable findings to substantiate or explain the degree of
25 pain she alleges. Range-of-motion testing of her shoulders and
26 neck have been largely unremarkable, as well. Yet, rather than
27 simply rejecting Paulson's subjective complaints out of hand, the
28 ALJ gave her the benefit of the doubt and took her complaints into

1 consideration in determining Paulson's RFC, including restrictions
2 to account for her limitations.

3 The court finds the ALJ complied with the SSR, the applicable
4 regulations, and case law interpreting them. He provided clear,
5 convincing reasons for discounting Paulson's subjective complaints
6 and finding them not to be fully credible. The Commissioner's
7 decision on this point should be affirmed.

8
9 **B. Third-Party Testimony**

10 Paulson argues the ALJ erred in failing to discuss how
11 Paulson's symptoms, as observed and reported by her husband, would
12 limit Paulson's ability to work. "Lay testimony as to a claimant's
13 symptoms is competent evidence that an ALJ must take into account,
14 unless he or she expressly determines to disregard such testimony
15 and gives reasons germane to each witness for doing so." *Lewis v.*
16 *Apfel*, 236 F.3d 503, 511 (9th Cir. 2001) (citing *Nguyen v. Chater*,
17 100 F.3d 1462, 1467 (9th Cir. 1996), in turn citing *Dodrill v.*
18 *Shalala*, 12 F.3d 915, 918-19 (9th Cir. 1993)).

19 Here, the ALJ found Charles Paulson's testimony "credible to
20 the extent that he has accurately reported what he has seen, what
21 has been exhibited to him, and what he has been told. [However,]
22 [w]hile he is credible, behavior exhibited or symptoms reported by
23 a subject are not an adequate basis to establish disability."
24 (A.R. 24) Instead of giving "reasons germane to" Charles to
25 justify discounting his testimony, the ALJ stated, "In finding
26 [Paulson] is not precluded from performing basic work activity, the
27 undersigned is more persuaded by the opinions from medical
28 professionals who are trained to evaluate impairments and their

1 impact on functional capacity." (A.R. 24-25) This justification
2 is inadequate as a matter of law. Not only must the ALJ provide
3 reasons germane to Charles Paulson, the ALJ's reasons "must be
4 specific." *Bruce v. Astrue*, 557 F.3d 1113, 1116 (9th Cir. 2009)
5 (citing *Stout v. Comm'r*, 454 F.3d 1050, 1054 (9th Cir. 2006) ("the
6 ALJ, not the district court, is required to provide specific
7 reasons for rejecting lay testimony")). The *Bruce* court made it
8 clear that an ALJ must "consider and comment upon competent lay
9 testimony, as it concern[s] how [the claimant's] impairments impact
10 [her] ability to work." *Bruce*, 557 F.3d at 1115-16. The
11 applicable regulation explains that the testimony of non-medical
12 sources, such as a spouse, is competent evidence regarding how the
13 severity of a claimant's impairments affects the claimant's ability
14 to work. 20 C.F.R. § 404.1513(d)(4).

15 Nevertheless, the undersigned finds the ALJ's error was
16 harmless, in that it was "'inconsequential to the ultimate non-
17 disability determination' in the context of the record as a whole."
18 *Molina v. Astrue*, 674 F.3d 1104, 1121 (9th Cir. 2012) (quoting
19 *McLeod v. Astrue*, 640 F.3d 881, 888 (9th Cir. 2011)). Spe-
20 cifically, the symptoms and limitations about which Charles Paulson
21 testified mirrored Paulson's own testimony about her limitations -
22 testimony the court has found the ALJ properly rejected based on
23 clear and convincing reasons. "[A]n ALJ's failure to comment upon
24 lay witness testimony is harmless where 'the same evidence that the
25 ALJ referred to in discrediting [the claimant's] claims also
26 discredits [the lay witness's] claims.'" *Id.* at 1122 (quoting
27 *Buckner v. Astrue*, 646 F.3d 549, 560 (8th Cir. 2011)). "Because
28 the ALJ had validly rejected all the limitations described by the

1 lay witness in discussing [the claimant's] testimony, we are
 2 confident that the ALJ's failure to give specific . . . reasons for
 3 rejecting the lay testimony did not alter the ultimate nondisa-
 4 bility determination. Accordingly, the error was harmless." *Id.*
 5 Thus, the ALJ's failure to give appropriate reasons for rejecting
 6 Charles Paulson's testimony does not require remand for further
 7 consideration of that testimony. *See id.*

8 9 **C. Weight Given to Physicians' Opinions**

10 Paulson argues the ALJ erred in failing to give greater weight
 11 to the opinions of her "Treating And Examining Physicians." Dkt.
 12 #19, p. 11. She cites case law regarding the weight to be given to
 13 the opinion of a treating *physician*, but the only opinion to which
 14 she refers is that of PA Macdonald. While the observations of a
 15 physician's assistant may be considered by an ALJ in determining
 16 the severity of a claimant's impairments, only "acceptable medical
 17 sources" may "provide evidence to establish an impairment." 20
 18 C.F.R. § 404.1513(a). An ALJ may disregard the opinions of a
 19 physician's assistant if the ALJ "'gives reasons germane to each
 20 witness for doing so.'" *Turner v. Comm'r*, 613 F.3d 1217, 1224
 21 (citing *Lewis*, 236 F.3d at 511).

22 Here, the ALJ considered PA Macdonald's progress notes from
 23 her treatment of Paulson, but with regard to her opinion that
 24 Paulson is "disabled," the ALJ noted PA Macdonald, herself,
 25 acknowledged "she is not trained to complete the 'tests of func-
 26 tional capacity.'" (A.R. 26) The ALJ noted the record evidence
 27 does not support PA Macdonald's report that Paulson suffers from
 28 muscle weakness. (*Id.*) The court agrees that PA Paulson was not

1 qualified to express an opinion regarding Paulson's functional
2 abilities in the workplace.

3 Further, even an opinion from one of Paulson's treating
4 physicians that she is "disabled" would not automatically have
5 resulted in a determination that Paulson is disabled. The deter-
6 mination of disability is expressly reserved to the Commissioner,
7 as one of the "administrative findings that are dispositive of a
8 case[.]" 20 C.F.R. § 404.1527(d)(1). As such, the Commissioner
9 gives no "special significance" to such an opinion. 20 C.F.R.
10 § 404.1527(d)(3).

11 The court finds the ALJ did not err in failing to give greater
12 weight to PA Macdonald's opinion that Paulson is disabled. The
13 Commissioner's decision should be affirmed on this point.

14 15 **VI. CONCLUSION**

16 For the reasons discussed above, I recommend the Commis-
17 sioner's decision be affirmed.

18 19 **VII. SCHEDULING ORDER**

20 These Findings and Recommendations will be referred to a
21 district judge. Objections, if any, are due by **February 11, 2013**.
22 If no objections are filed, then the Findings and Recommendations
23 will go under advisement on that date. If objections are filed,
24 then any response is due by **February 28, 2013**. By the earlier of
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1 the response due date or the date a response is filed, the Findings
2 and Recommendations will go under advisement.

3 IT IS SO ORDERED.

4 Dated this 23rd day of January, 2013.

5
6 /s/ Dennis J. Hubel

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Dennis James Hubel
Unites States Magistrate Judge